UCDA Employee Benefits

Master Group Application

To be completed by authorized official of company

MANDATORY
UCDA MEMBER #

The completion of this Master Application does not guarantee insurance coverage.

Part 1 - Company Information:

Company Name: _____ Type of Business: _____

Street: _____ Unit Number: _____

City: _____ Province _____ Postal Code: _____

Phone Number: _____ Fax Number: _____ Email: _____

Main Contact and Title: _____ # eligible employees: _____

Type of Ownership: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation # of employees covered: _____

UCDA Member # _____ Employee Eligibility Period: 90 days, except current employees

Part 2 - Present Coverage:

Will the insurance being applied for replace similar insurance? ☐ Yes ☐ No
If "Yes", provide a full copy of current billing statement with this application.

IMPORTANT: TO AVOID A PERIOD WITHOUT COVERAGE, DO NOT CANCEL ANY EXISTING COVERAGE UNTIL NOTICE HAS BEEN GIVEN IN WRITING THAT THE COVERAGE BEING APPLIED FOR HAS BEEN APPROVED BY THE CAPITAL GROUP INSURANCE. THE EFFECTIVE DATE OF COVERAGE WILL USUALLY BE THE FIRST DAY OF THE NEXT MONTH FOLLOWING APPROVAL.

Part 3 - Plan Design: *Benefits selected will apply to all plan participants.*

☑ **Health & Dental Insurance - MANDATORY**
80% drug & extended health, 80% dental, includes premium year-round travel insurance. See details.

❑ **Life Insurance & AD&D - OPTIONAL**
1-9 members - $25k only (medical evidence required if have 1-4 members); *10+ members* $25k, $50k or $75k.
AD&D doubles benefit if death occurs by accident.
Choose amount: ☐ $25k ☐ $50k ☐ $75k

❑ **Dependent Life Insurance - OPTIONAL**
(Must be selected when Life and AD&D selected.)
Benefit includes Dependent AD&D.
❑ $5,000 spouse / $2,500 child
❑ $10,000 spouse / $5,000 child

❑ **Critical Illness Insurance - OPTIONAL**
Pays face amount upon diagnosis of one of 15 covered conditions. $20k is guaranteed-issue.
❑ $20k ❑ $30k ❑ $40k ❑ $50k

❑ **Short Term Disability Insurance - OPTIONAL**
Income protection - 1st day accident, 8th day sickness.
67% of pre-disability income for max. 117 days.
Maximum $700 per week benefit.

❑ **Long Term Disability Insurance - OPTIONAL**
Income protection - 117 day waiting period.
67% of pre-disability income until age 65.
Maximum $4,000 a month benefit.

❑ **Lifestyle Account - OPTIONAL**
A healthcare spending account, for items not covered under this group plan. Use for pre-existing drugs, vision care, orthodontics, cosmetic procedures, and much more.

Part 4 - Short & Long Term Disability *Complete only if you are selecting disability insurance.*

(a) Are all participants who are eligible for STD and LTD covered by a Worker's Compensation or a similar plan? _____

(b) Is disability insurance funded by the employer ❑ (taxable)or the employee ❑ (non-taxable)?

(c) Have any employees applying for disability under this plan been absent from work due to any one disability for more than 7 consecutive days over the past 12 months? ❑ YES ❑ NO If "YES", name: _____

(d) How many of the employees (including owners) operate business out of their residence? _____

(e) Are there any employees employed on a contract, consultant, sub-contractor, or seasonal basis to be insured for coverage under this plan?
❑ YES ❑ NO

(f) Minimum number of hours for Full Time Employees: _____ (g) Number of seasonal employees to be covered: _____

Part 5 - Pre-authorized Payment (PAP) - *Mandatory*

The client certifies that the information provided in this authorization is correct and that the client will notify the administrator in the event of any changes. The client certifies that his/her bank account is in good standing with sufficient funds to cover pre-authorized payments as they come due. All pre-authorized payments will be drawn on Canadian financial institutions only and will be withdrawn in Canadian funds.

❑ YES, I/we hereby authorize Canadian Benefit Administrators to withdraw the amount due on my/our billing statement from my/our financial institution on the 1st day of each month (or the next business day.)

PLEASE ATTACH A 'VOID' CHEQUE

Part 6 - Ontario Retail Sales Tax (RST) - Election Form

❑ YES, the applicant for this group insurance policy elects to remit the full Ontario Retail Sales tax payable on both the employee and employer premiums to Canadian Benefit Administrators in accordance with Regulation 1013 of the Revised Regulations of Ontario, 1990 made under the Retail Sales Tax Act, Section 3.1(3) and 3.2(3), as applicable.

Authorization, Declaration and Acknowledgement

I, the undersigned, hereby declare that the answers given on this Master Application are true and accurate to the best of my knowledge. I understand that the coverage being applied for through the UCDA Health and Dental Plan will not commence until written letter of approval has been received. I understand that this coverage will not become effective until the date indicated on the letter of approval. I understand that the insurer reserves the right to cancel the insurance should the information contained in this master application be determined to be false. A deposit equal to two (2) month's premium has been submitted with this application (for groups under 5.)

The term of this agreement shall be for not less than 12 months, and will continue thereafter indefinitely until the applicant notifies The Capital Group Insurance in writing. Renewal of coverage is not guaranteed, and subject to the sole discretion of The Capital Group Insurance.

Your Privacy is Protected: The insurance coverage you are applying for is underwritten by various insurers and administered by Canadian Benefit Administrators (CBA) and The Capital Group Insurance Inc. These parties collect, use and disclose the personal information which you give for the purpose of providing you with insurance services. The applicant confirms that it has obtained individual plan member consent to the collection, use and disclosure of member personal information (including personal information about member dependent(s)) required for plan enrolment and ongoing administration of the plan.

An initial premium deposit of $_____ is included with this application. Negotiation of the cheque will not, of itself, constitute approval of the application.

Dated at _____ this ____ day of _____ _____.
City, Prov. Month Year

Applicant (full company name): _____

Signature and title of authorized official: _____

Please submit your completed application to The Capital Group Insurance Inc.:
14-3650 Langstaff Rd., Suite 123, Woodbridge, ON L4L 9A8 Phone: 1-866-476-8722 Fax: 1-888-416-8267

THE CAPITAL GROUP Insurance Inc.